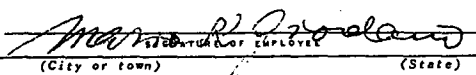


CONFIDENTIAL  
(When Filled In)

THE FURNISHING OF THIS FORM IS FOR THE CONVENIENCE OF THE SUBSCRIBER AND IS NOT AN ACKNOWLEDGEMENT OF LIABILITY OR WAIVER OF ANY RIGHT.				GOVERNMENT EMPLOYEES HEALTH ASSOCIATION CLAIM			
<b>SECTION I SUBSCRIBER'S CLAIM AND CERTIFICATION</b>							
1. FULL NAME OF EMPLOYEE (Subscriber)		2. NAME (If claim for dependent)		3. RELATIONSHIP		4. AGE	
Mario K. Giordano (P)				-		61	
5. DATE INJURED OR BEGINNING OF SICKNESS		TIME					
7 June 1965		A.M.		P.M.			
6. INDICATE NATURE OF INJURY OR SICKNESS							
Anemia, arthritis, low blood pressure							
7. REASON FOR DIAGNOSTIC TESTS (X-rays, laboratory tests, etc.)							
To find the source of the troubles.							
8. IF AN INJURY, STATE WHEN, WHERE AND HOW IT OCCURRED (State whether sickness or injury occurred on job)							
9. ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED UNDER ANY PLAN OR PLANS OTHER THAN GEHA FOR WHICH PAYROLL DEDUCTIONS ARE MADE, OR FOR WHICH AN EMPLOYER MAKES A CONTRIBUTION IN WHOLE OR IN PART, OR UNDER FEDERAL, STATE, OR OTHER GOVERNMENTAL PROGRAM WHICH PROVIDES BENEFITS FOR THIS ILLNESS OR ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10. IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY OR OTHER ORGANIZATION PROVIDING SUCH COVERAGE AND AMOUNT THE OTHER INSURANCE COMPANY HAS PAID OR WILL PAY ON THIS CLAIM.							
11. DATE		12. I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE					
24 December 1965							
13. ADDRESS (Street and No.)		(City or town)		(State)			
PLEASE ATTACH ITEMIZED BILLS							
<b>SECTION II INSTRUCTIONS FOR DISPOSITION OF CHECK</b>							
1. <input checked="" type="checkbox"/> CHECK WILL PERSON		2. <input type="checkbox"/> CHECK WILL BE SENT VIA INTRA-OFFICE MAIL		CALL EXT.			
				4205			
2. <input type="checkbox"/>				ROOM NO.		BUILDING EXT.	
<b>SECTION III REMARKS</b>							

FORM 1618 USE PREVIOUS EDITIONS.

CONFIDENTIAL

GROUP 1  
Excluded from automatic  
downgrading and declassification

(4)

DECLASSIFIED AND RELEASED BY  
CENTRAL INTELLIGENCE AGENCY  
SOURCES METHOD EXEMPTION 3B2B  
NAZI WAR CRIMES DISCLOSURE ACT  
DATE 2006

MEDICAL EXPENSE RECORD FOR SUBMISSION OF CLAIM (Major Medical Only)				
NAME OF PERSON FOR WHOM EXPENSES WERE INCURRED		RELATIONSHIP	DATE OF BIRTH	
NAME OF INSURED				
Mario K. GIORDANO (P)			13 Sept 1904	
<p>IMPORTANT - AN ITEMIZED BILL OR RECEIPT MUST BE ATTACHED TO THIS FORM FOR EACH ITEM OF EXPENSE FOR WHICH CLAIM IS MADE. All bills or receipts should include (1) name of patient, (2) the nature of illness or injury, (3) type of service, (4) description of surgery performed, (5) date(s) service was rendered, (6) amount charged and (7), if drugs, the prescription number and pharmacy.</p>				
NATURE OF ILLNESS	TYPE SERVICE & BY WHOM GIVEN	Date Charges Incurred		TOTAL CHARGE
		From	To	
	See GIORDANO's itemized account attached			
A SEPARATE FORM MUST BE SUBMITTED FOR EACH PERSON COVERED				GRAND TOTAL

Year: 1965

Name: Mario K. Giordano

Paid to:	Paid for		Date incurred From To.	Cost	Amt. Paid by Basic Plan	Balance Eligible for Major Medical
	Illness	Type of Service.				
Argyle Pharmacy	Anemia & arthritis	Drug #313176, Tylenol	6/7	6.--	-	6.00
Casualty Hospital	"	Room for three days	6/29-7/1	69.--	60.--	9.--
" "	"	Pharmacy **	" "	10.15	10.15	-
" "	"	Sterile trays **	" "	10.--	10.--	-
" "	"	X-rays **	" "	65.--	65.--	-
" "	"	Laboratory tests etc. **	" "	32.--	32.--	-
" "	"	EKG **	" "	15.--	15.--	-
Taxi	"	To and from hospital	" "	3.--	3.--	-
Dr. Hantsoo	"	Treatment in Hospital	" "	42.--	42.--	-
Dr. Hantsoo	"	CBC in Casualty Hospital	7/26; 8/17; 10/19.	18.--	18.--	-
Taxis	#	" " " "To/From.	" " "	9.--	9.--	-
Dr. Hantsoo	"	28 Office visits & injections	6/7 to 12/23	153.--	-	153.--
Taxis	"	3 times to Dr. H's Office	6/7-6/17 (3x3)	9.--	-	9.--
Taxis & buses	"	25 times " " " "	7/6-12/23 (1.5x25)	37.50	-	37.50
Totals:				\$ 478.65; 264.15;		214.50

\*: Out-patient care.

\*\*: Hospital extras, all together \$ 132.15.

24 December 1965.

